

## Oregon Client Acuity Scale Worksheet

**"Confidential- this form must always be saved on a secure network accessible only by Ryan White funded staff"**

Client name \_\_\_\_\_ Date of assessment \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Total points \_\_\_\_\_ Assigned acuity level \_\_\_\_\_

Clients are assigned to a level if they meet one or more of the criteria listed within each level.

Point values are different for different Life Areas by page.

### Psychosocial assessment (part A)

Life area	Level #1 (1 point)	Level #2 (2 points)	Level #3 (3 points)	Level #4 (4 points)
<b>Basic needs</b>  Level _____ Points _____	<input type="checkbox"/> Food, clothing and other sustenance items available through client's own means. <input type="checkbox"/> Has ongoing access to assistance programs that maintain basic needs consistently. <input type="checkbox"/> Able to perform activities of daily living (ADL) independently.	<input type="checkbox"/> Sustenance needs met on a regular basis with occasional need for help accessing assistance programs. <input type="checkbox"/> Unable to routinely meet basic needs without emergency assistance. <input type="checkbox"/> Needs assistance to perform some ADL weekly.	<input type="checkbox"/> Routinely needs help accessing assistance programs for basic needs. <input type="checkbox"/> History of difficulties in accessing assistance programs on own. <input type="checkbox"/> Often w/o food, clothing or other basic needs. <input type="checkbox"/> Needs in-home ADL assistance daily.	<input type="checkbox"/> Has no access to food. <input type="checkbox"/> Without most basic needs. <input type="checkbox"/> Unable to perform most ADL. <input type="checkbox"/> No home to receive assistance with ADL.
<b>Transportation</b>  Level _____ Points _____	<input type="checkbox"/> Has own or other means of transportation consistently available. <input type="checkbox"/> Can drive self. <input type="checkbox"/> Can afford private or public transportation.	<input type="checkbox"/> Has minimal access to private transportation. <input type="checkbox"/> Needs occasional assistance with finances for transportation.	<input type="checkbox"/> No means via self/others. <input type="checkbox"/> In area under or un- served by public transportation. <input type="checkbox"/> Unaware of or needs help accessing transportation services.	<input type="checkbox"/> Lack of transportation is a serious contributing factor to current crisis. <input type="checkbox"/> Lack of transportation is a serious contributing factor to lack of regular medical care.
<b>Risk reduction</b>  Level _____ Points _____	<input type="checkbox"/> Abstaining from risky behavior by safer practices. <input type="checkbox"/> Client has good understanding of risks.	<input type="checkbox"/> Occasional risk behavior ( <i>unsafe behaviors of any type &lt;=20% of the time</i> ). <input type="checkbox"/> Client has fair understanding of risks.	<input type="checkbox"/> Moderate risk behavior ( <i>unsafe behaviors of any type &gt;20-50% of the time</i> ). <input type="checkbox"/> Client has poor understanding of risks. <input type="checkbox"/> Client with mild/moderate A&D, MH, or relationship barriers to safer behavior.	<input type="checkbox"/> Declines to answer. <input type="checkbox"/> Significant risk behavior ( <i>unsafe behaviors of any type &gt;50% of the time</i> ). <input type="checkbox"/> Client has little or no understanding of risks. <input type="checkbox"/> Client with significant A&D, MH, or relationship barriers to safer behavior.
<b>Health insurance/medical care coverage</b>  Level _____ Points _____	<input type="checkbox"/> Has insurance/medical care coverage. <input type="checkbox"/> Has ability to pay for care on own. <input type="checkbox"/> Enrolled in CAREAssist.	<input type="checkbox"/> Client needs information and referral to insurance or other coverage for medical costs.	<input type="checkbox"/> Case management assistance needed in accessing insurance or other coverage for medical costs ( <i>such as prescription drug coverage</i> ). No medical crisis.	<input type="checkbox"/> Needs immediate assistance in accessing insurance or other coverage for medical costs due to medical crisis. <input type="checkbox"/> Not currently eligible for insurance or public benefits. Unable to access care.

Life area	Level #1 (1 point)	Level #2 (2 points)	Level #3 (3 points)	Level #4 (4 points)
<b>Self sufficiency</b>  Level _____  Points _____	<input type="checkbox"/> Independently always follows up on referrals. <input type="checkbox"/> Able to complete forms independently. <input type="checkbox"/> Able to live within financial means. Never needs financial assistance. <input type="checkbox"/> Does not burn bridges. Is able to access services eligible for and are available.	<input type="checkbox"/> Sometimes requires assistance in following-up on referrals. <input type="checkbox"/> Sometimes requires assistance in completing forms. <input type="checkbox"/> Needs financial assistance 1-2 times per year. <input type="checkbox"/> Access to some limited services.	<input type="checkbox"/> Follows-up on referrals with difficulty. <input type="checkbox"/> Difficulty completing forms. <input type="checkbox"/> Needs financial assistance 3-6 times per year. <input type="checkbox"/> Difficulty accessing services.	<input type="checkbox"/> Never follows-up on referrals. <input type="checkbox"/> Unable to complete forms. <input type="checkbox"/> Routinely needs financial assistance 6+ times per year. <input type="checkbox"/> Burns bridges. Majority of services not available.

Life area	Level #1 (1point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
<b>Housing/living arrangement</b>  Level _____ Points _____	<input type="checkbox"/> Living in housing of choice: clean, habitable apartment or house. <input type="checkbox"/> Living situation stable; not in jeopardy.	<input type="checkbox"/> Living in stable subsidized housing ( <i>public housing, private subsidized housing, or secure Section-8 voucher</i> ). <input type="checkbox"/> Safe & secure nonsubsidized housing, but choices limited due to moderate income. <input type="checkbox"/> Housing is habitable, but requires limited improvements. <input type="checkbox"/> Housing is in jeopardy due to projected. Financial strain (>30 days); needs assistance with rent/utilities to maintain housing. <input type="checkbox"/> Living in long-term (>3 mo.) transitional rental housing.	<input type="checkbox"/> Formerly independent person temporarily residing with family or friends. <input type="checkbox"/> Eviction imminent. <input type="checkbox"/> Living in temporary (<3 mo.) transitional shelter. <input type="checkbox"/> Housing is in jeopardy due to immediate projected financial strain (<30 days); needs assistance with rent/utilities to maintain housing.	<input type="checkbox"/> Needs assisted living facility; unable to live independently. <input type="checkbox"/> Home uninhabitable due to health and/or safety hazards. <input type="checkbox"/> Recently evicted from rental or residential program. <input type="checkbox"/> Homeless ( <i>living in emergency shelter, car, on street/camping, etc...</i> ).
<b>Mental health</b>  Level _____ Points _____	<input type="checkbox"/> No history of mental illness, psychological disorders or psychotropic medications. <input type="checkbox"/> No need for counseling referral.	<input type="checkbox"/> History of mental health disorders/treatment in client and/or family. <input type="checkbox"/> Level of client/family stress is high. Needs emotional support to avert crisis. <input type="checkbox"/> Need for counseling referral. <input type="checkbox"/> Depression, functioning. <input type="checkbox"/> Has some trouble getting along with others.	<input type="checkbox"/> Experiencing an acute episode and/or crisis. <input type="checkbox"/> Severe stress or family crisis re:HIV; need for mental health assessment. <input type="checkbox"/> Depression, not functioning. <input type="checkbox"/> Requires significant emotional support. <input type="checkbox"/> Significant trouble getting along with others.	<input type="checkbox"/> Danger to self or others. <input type="checkbox"/> Needs immediate psychiatric assessment/evaluation. <input type="checkbox"/> Active chaos or problems due to violence or abuse. <input type="checkbox"/> Requires therapy, not accessing it.
<b>Addictions</b>  Level _____ Points _____	<input type="checkbox"/> No difficulties with addictions including: alcohol, drugs, sex, or gambling. <input type="checkbox"/> Past problems with addiction; >1yr. In recovery. <input type="checkbox"/> No need for treatment referral.	<input type="checkbox"/> Past problems with addiction; < 1 year in recovery.	<input type="checkbox"/> Current addiction but is willing to seek help in overcoming addiction. <input type="checkbox"/> Major addiction impairment of significant other. <input type="checkbox"/> Past problems with addictions; <3 months in recovery.	<input type="checkbox"/> Current addiction; not willing to seek or resume treatment. <input type="checkbox"/> Fails to realize impact of addiction on life/indifference regarding consequences of substance use.

**RN assessment (part B)**

Life area	Level #1 (1 point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
<b>Knowledge of HIV disease</b> Level _____ Points _____	<input type="checkbox"/> Verbalizes clear understanding about disease.	<input type="checkbox"/> Some understanding verbalized. <input type="checkbox"/> Needs additional information in some areas.	<input type="checkbox"/> Little understanding. <input type="checkbox"/> Needs counseling or referral to make informed decisions about health.	<input type="checkbox"/> Ignorant of HIV disease progression, etc. Unable to make informed decisions about health.
<b>Adherence</b> Level _____ Points _____	<input type="checkbox"/> Adherent to medications as prescribed for more than 6 months without assistance. <input type="checkbox"/> Currently understands medications. <input type="checkbox"/> Able to maintain primary care. <input type="checkbox"/> Keeps medical appointments as scheduled. <input type="checkbox"/> Not currently being prescribed medications.	<input type="checkbox"/> Adherent to medications as prescribed with minimal assistance. <input type="checkbox"/> Keeps majority of medical appointments.	<input type="checkbox"/> Adherent to medications and treatment plan with regular, ongoing assistance. <input type="checkbox"/> Doesn't understand medications. <input type="checkbox"/> Misses taking or giving several doses of scheduled meds weekly. <input type="checkbox"/> Misses at least half of scheduled medical appointments. <input type="checkbox"/> Takes long/extended "drug holidays" AMA. <input type="checkbox"/> Takes non- HIV systemic therapies without MD knowledge.	<input type="checkbox"/> Resistance/minimal adherence to medications and treatment plan even with assistance. <input type="checkbox"/> Refuses/declines to take medications against medical advice. <input type="checkbox"/> Medical care sporadic due to many missed appointments. <input type="checkbox"/> Uses ER only for primary care. <input type="checkbox"/> Inability to take/give meds as scheduled; requires professional assistance to take/give meds and keep appointments.
<b>Medical needs</b> Level _____ Points _____	<input type="checkbox"/> Stable health with access to ongoing HIV medical care. <input type="checkbox"/> Lab work periodically. <input type="checkbox"/> Asymptomatic in medical care.	<input type="checkbox"/> Needs primary care referral. <input type="checkbox"/> HIV care referral needed-stable. <input type="checkbox"/> Short-term acute condition; receiving medical care. <input type="checkbox"/> Chronic non-HIV related condition under control with medication/treatment. <input type="checkbox"/> HIV symptomatic with one or more conditions that impair overall health.	<input type="checkbox"/> Poor health. <input type="checkbox"/> HIV care referral needed-ASAP. <input type="checkbox"/> Needs treatment or medication for non-HIV related condition. <input type="checkbox"/> Debilitating HIV disease symptoms/infections. <input type="checkbox"/> Multiple medical diagnoses. <input type="checkbox"/> Home bound; home health needed.	<input type="checkbox"/> Medical emergency. <input type="checkbox"/> Client is in end-stage of HIV disease. <input type="checkbox"/> Intensive/complicated home care required. <input type="checkbox"/> Hospice services or placement indicated.
<b>Nutrition</b> Level _____ Points _____	<input type="checkbox"/> No signs of wasting syndrome or obvious physical maladies. <input type="checkbox"/> No abdominal pain reported. <input type="checkbox"/> No significant weight problems. <input type="checkbox"/> No problems with eating. <input type="checkbox"/> No problems with nausea or vomiting or diarrhea. <input type="checkbox"/> No need for nutritional intervention.	<input type="checkbox"/> Unplanned weight loss in the past 6 months. <input type="checkbox"/> Requests assistance in improving nutrition. <input type="checkbox"/> Occasional episodes of nausea, vomiting or diarrhea.	<input type="checkbox"/> Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies < not advanced >. <input type="checkbox"/> Abdominal problems reported. <input type="checkbox"/> Changes in eating habits in the past 3 months. <input type="checkbox"/> Chronic nausea, vomiting and/or diarrhea.	<input type="checkbox"/> Visual assessment shows advanced signs of wasting syndrome or other obvious physical maladies. <input type="checkbox"/> Acute abdominal pain. <input type="checkbox"/> Severe problems eating. <input type="checkbox"/> Acute nausea, vomiting and/or diarrhea. <input type="checkbox"/> Significant weight loss in past 3 months.
<b>Oral health</b> Level _____	<input type="checkbox"/> Is currently in active dental care. <input type="checkbox"/> Has seen dentist in past six months.	<input type="checkbox"/> Does not have a regular dentist. <input type="checkbox"/> No dental insurance. <input type="checkbox"/> Has not seen a dentist in more	<input type="checkbox"/> Reports episodic pain and/or sensitivity in teeth, gums or mouth. <input type="checkbox"/> Missing days from work because of problems with teeth, gums or	<input type="checkbox"/> Current tooth, gum or mouth pain and severe discomfort. <input type="checkbox"/> Very few or no teeth.

Client name: \_\_\_\_\_

Life area	Level #1 (1 point)	Level #2 (4 points)	Level #3 (6 points)	Level #4 (8 points)
Points _____	<input type="checkbox"/> No complaints of mouth, tongue, tooth or gum pain and teeth and gums appear healthy as observed during assessment. <input type="checkbox"/> Client reports practicing daily oral hygiene.	than 6 months. <input type="checkbox"/> Client reports not practicing daily oral hygiene. <input type="checkbox"/> Dentures need adjusting, but still able to eat.	mouth. <input type="checkbox"/> Client reports difficulty interacting with others because oral health problems negatively impact self-esteem. <input type="checkbox"/> Observed appearance of dark, discolored teeth; missing teeth; bleeding, red gums; other problems with mouth. <input type="checkbox"/> Client reports episodic or moderate difficulty eating.	<input type="checkbox"/> Observed appearance or client report of decayed teeth; white, hairy growth or creamy, bump-like patches; oral lesions or bleeding from gums/teeth. <input type="checkbox"/> Client reports significant difficulty eating due to oral health problems. <input type="checkbox"/> Client has difficulty talking because of oral health problems.

## Acuity level guidelines

### Level 1: 13-22 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Annual face-to-face nursing reassessment and psychosocial rescreening.
- Documentation in progress notes or CAREWare case notes.
- Ongoing nurse consultation as needed.
- Nurse and psychosocial Care Plan developed, appropriate intervention identified and ongoing follow-up provided.
- Care Plan Form (DHS 8400) updated annually.

### Level 2: 23-42 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Annual face-to-face nursing reassessment and psychosocial screening.
- Minimum contact (telephone or face-to-face) every 6 months to verify address/phone number and to check on client's current status.
- Ongoing nurse consultation as needed.
- Nurse and psychosocial Care Plan developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

### Level 3: 43-63 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Minimum annual face-to-face nursing reassessment and psychosocial re-screening.
- Minimum contact (telephone or face-to-face) every 30 days.
- Minimum evaluation of goals, activities and outcomes every 30 days.
- Nurse must be consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's file a minimum of every 90 days.
- Nurse and psychosocial Care Plan (Care Plan form) developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

### Level 4: 64-84 points

- Initial face-to-face nursing assessment and psychosocial screening.
- Minimum annual face-to-face nursing reassessment and psychosocial rescreening.
- Minimum contact (telephone or face-to-face) every 2 weeks.
- Minimum evaluation of goals, activities and outcomes every 2 weeks.
- Nurse is consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's file a minimum of every 30 days.
- Nurse and psychosocial Care Plan (Care Plan form) developed, appropriate intervention identified and ongoing follow-up provided.
- Care planning, goals, activities and outcomes documented on the Care Plan Form (DHS 8400) and updated every 6 months.

**Exceptions:** \* At the discretion of the Nurse Case Manager, release from a correctional facility may be a condition warranting an Acuity Level 3 during the first 90 days after release. The Nurse Case Manager may assign an overall acuity of 3 or 4 if a client is assessed a level 3 or level 4 in the "Medical Needs" life area. Follow-up standards for these acuity levels will apply.